

**Vivitrol / Campral
Prior Authorization Form**

Patient's Information:

Date: _____

Name: _____ DOB: _____

Participant's Maryland Medicaid Number: _____

Prescriber's Information:

Name: _____ NPI #: _____

Phone #: _____ Fax #: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

Medication: _____ **Strength:** _____ **Quantity:** _____ **Refills:** _____

Directions for Use: _____

Check each box below that applies for the requested medication.

Please Note: For the initial prescription, a participant will be allowed a 90 day supply (original + 2 refills).

Vivitrol Criteria

- ☐ Please indicate diagnosis of opioid or alcohol use disorder (circle one)
- ☐ Negative urine test results for opioids or MD to provide documentation that the patient has passed a naloxone challenge test in the past 7 days
- ☐ Negative test result for alcohol in the past 7 days (Required for alcohol use disorder only)

Campral Criteria

- ☐ Diagnosis of alcohol use disorder
- ☐ Negative test result for alcohol in the past 7 days
- ☐ History of Naltrexone or Disulfiram therapy
- ☐ Creatinine Clearance is > 50 ml/min

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber's Signature _____ **Date** _____

Fax this completed form to 866-440-9345, once all the required information has been provided. **Incomplete forms will not be reviewed.**

<https://store.samhsa.gov/shin/content/SMA14-4892R/SMA14-4892R.pdf> <https://www.vivitrol.com/content/pdfs/prescribing-information.pdf>

Internal Use only- Information below is to be completed by the PA pharmacist

- | | |
|------------------------------|---|
| For Vivitrol Criteria | <input type="checkbox"/> No opioid claim in the past 7 days |
| For Campral Criteria | <input type="checkbox"/> Claims history of Naltrexone or Disulfiram therapy |